Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Baylor Surgicare at Heath

Respondent Name
Texas Mutual Insurance Co

MFDR Tracking Number
M4-14-1293-01

Carrier's Austin Representative Box
Box Number 54

MFDR Date Received
January 9, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "At this time we are requesting that this claim paid in accordance with the 2013 Texas Workers Compensation Fee Schedule and Guidelines."

Amount in Dispute: $2,786.22

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "No additional payment is due for codes 63685, L8681, and L8689."

Respondent: Texas Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 26, 2013	63685, L8687, L8681, L8689	$2,786.22	$2,786.22

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.402 sets out reimbursement guidelines for medical services, charges and payments.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
   - 420 – Supplemental payment
   - 897 - Separate reimbursement for implantables made in accordance with DWC Rule Chapter 134: Subchapter (E) Health Facility Fees

Issues

1. What is the applicable rule to calculate reimbursement?
2. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §134.402(f) states, "The reimbursement calculation used for establishing the MAR shall be the Medicare ASC reimbursement amount determined by applying the most recently adopted and effective Medicare Payment System Policies for Services Furnished in Ambulatory Surgical Centers and Outpatient Prospective Payment System reimbursement formula and factors as published annually in the Federal Register. Reimbursement shall be based on the fully implemented payment amount as in ADDENDUM AA, ASC COVERED SURGICAL PROCEDURES FOR CY 2008, published in the November 27, 2007 publication of the Federal Register, or its successor. The following minimal modifications apply:
   (1) Reimbursement for non-device intensive procedures shall be:
      (A) The Medicare ASC facility reimbursement amount multiplied by 235 percent; or
      (B) if an ASC facility or surgical implant provider requests separate reimbursement for an implantable, reimbursement for the non-device intensive procedure shall be the sum of:
      (i) the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission; and
      (ii) the Medicare ASC facility reimbursement amount multiplied by 153 percent. …

   Review of the submitted documentation finds a request for implantables was made and considered by the carrier. The services in dispute will be calculated at the Medicare ASC Facility reimbursement amount multiplied by 153% or

Submitted Procedure Code	National Reimbursement from Addendum AA	Statistical Area Number	Wage Index for ASC	Divide National Reimbursement by 2	Multiply by National Wade Index	Add to National Reimbursement Sum	Medicare Adjusted ASC Reimbursement	Total MAR
63685	15,431.30	19124 Dallas TX	0.9844	15,431.30 ÷ 2 = $7,715.65	7715.65 x 0.9844 = $7,595.29	7715.65 + 7595.29 = $15,310.94	15,310.94	15310.94 x 153% = 23,425.74
							Total	$23,425.74

Submitted Code	Amount billed	Units	Implantable Description	Invoice Amount	Did documentation support item met the definition of "implantable"	Implants Maximum allowable reimbursement
L8687	12800.00	1	INS 37702 Prime ADV	$12,800.00	Yes	12800.00 + 10% (12800.00 + 1280) = $14,080.00
L8681	1071.00	1	Programmer 37746	1,071.00	Yes	1017.00 + 10% (1071.00 + 107) = $1,178.00
L8689	645.00	1	Accy 3550-29 Plug	$150.00	No	n/a
		1	Adaptor 74001 1x4 Pocket Adptr	$495.00	Yes	495.00 + 10% (495.00 + 49.50) = $544.50
					Total	$15,802.50

2. The total allowable for the disputed services is $39,228.24. The carrier paid $18,671.86. The requestor is seeking $2,786.22. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $2,786.22.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $2,786.22, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

		January 22 , 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.